

V. Hydrocele Neonatorum. By DR. WILHELM WECHSELMANN (Schwerin). This is a statistical paper on the frequency of hydrocele in the new born. The author made his observations in the Maternity Hospital of Dresden. Among about 270 boys 37 were affected with hydrocele. Of these 14 communicated with the peritoneal cavity. Only two hydroceles were situated on the left side, and these were communicating. In four cases the hydrocele was double. Most of the hydroceles were the size of a cherry, though some reached the size of a plum or over. The author concludes that hydrocele is much more frequent in the new born than is generally supposed. The hydrocele in these subjects communicates comparatively often with the peritoneal cavity. The hydrocele is found mostly present on the right side and is probably of intrauterine origin.—*Archiv. f. Chir.*, bd. 36, heft 3.

HENRY KOPLIK (New York).

VI. A Criticism of Langenbuch's Sectio alta Subpubica. By JOSEPH SMITS (Utrecht). The author briefly reviews and adversely criticises a new method of lithotomy recently published by Langenbuch and reviewed elsewhere in this journal. He regrets that the author did not adhere to his former (1881) endeavors to further elaborate Vidal de Cassis' method of performing the high section in two sittings.

[We may here briefly state that Langenbuch's present method consists in effecting an entrance into the bladder between the penis and the pubic arch.]

The author condemns Langenbuch's method of drainage in the after-treatment (consisting in the insertion of the tube through the perineum) as liable to injure the arteriæ pudenda interna and transversa bulbi. Furthermore the method only holds good when the arteriæ dorsales penis are normal in their course and origin, which is not always the case. Injury to the dorsal vein of the penis cannot always be avoided, nor is the opinion of many physicians, that this may cause impotence, to be entirely set aside. Cutting of the plexus santorini may occasion the malady called by Tillaux *cystite variqueuse*; and

cellulitis may ensue from severing the connection between the prostatic portion of the bladder with the symphysis.

The opening made cannot, in the opinion of the author, be large enough to permit the extraction of any but the smallest stones. Finally the operation is of no value in the case of children, for various reasons.—*Deutsche Zeitschr. f. Chir.*, Bd. 28, Hft. 3.

W. W. VAN ARSDALE (New York).

VII. Perineal Lithotrity. By REGINALD HARRISON, F.R.C.S. (Liverpool). The one great advantage of lithotomy over lithotrity is that it permits the surgeon to digitally explore the interior of the bladder, and so satisfy himself that no fragments are left behind. Mr. Harrison believes that many recurrences after lithotrity are due to some purely mechanical cause which either the operation or the operator fails to meet. He agrees with Mr. Donald Day's classification of the causes of recurrences, viz., (a) stones formed quite independently of the previous ones; (b) stones undetected at the first operation; (c) stones formed on a fragment left behind at a former operation; (d) includes stones of bladder formation, due to chronic cystitis. It appeared that three-fifths of the recurrences in Mr. Day's table were traceable to purely local causes, in which the bladder including its outlet was involved. Perineal litholapaxy would be well suited to cases in which it was required to (1) digitally explore the bladder and associated parts, both before and after removal of the stone; (2) the rapid evacuation of the stone; and (3) drainage and irrigation of the bladder should it be necessary.

Mr. Harrison has performed the operation in four cases, viz., three in which the prostate was enlarged, and it was deemed expedient to drain the bladder after removal of stone. In two instances litholapaxy had been previously performed. In the fourth case the stone was very large and could not be grasped in lithotrite. After the bladder was entered from the perineum the stone was easily crushed and removed. It was washed out with a solution of perchloride, and a large drainage tube inserted which was left in four days. Patient was well and up on the eleventh day passing all his urine per urethram. Mr. Harrison concludes "I hardly think I need apologise for bringing under notice